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Can We Be Partners?

A Case Study of Community Action and Local Food Systems Planning in Los Angeles

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ABSTRACT

Problem, research strategy, and findings: Sherry Arnstein castigated planners for their tokenistic participation processes. Since then, planning scholars and practitioners have attempted to improve these processes. We report on a Los Angeles (CA) case where Community Health Councils, Inc. (CHC) partnered with the city planners, public health officials, foundations, academics, and residents to pass a Health & Wellness Element in the General Plan Framework and integrate food issues into three community plans. We use a comparative multi-method approach interviewing officials and participants and documenting public meetings, strategy sessions, and other events. We find CHC did develop a successful partnership that represented an improvement over Arnstein's lower ladders. CHC's public comment letters had material impact on the language of the element's provisions. CHC's collaborative strategy resulted in inclusion of key food-related provisions in the updated West Adams Community Plan. The primary limitation is that our study ended prior to implementation, an area Arnstein accurately identified as a place where community power might be diminished.

Takeaway for practice: Planners working collaboratively with community groups can achieve significant improvements in their plans. This process successfully integrated food systems and other health issues into the element and three community plans.

Keywords: food, health disparities, participation, Sherry Arnstein

Since Sherry Arnstein (1969) castigated planners for their inequitable processes 50 years ago, planners have attempted to improve collaboration with residents to produce better communities. Between 2012 and 2016, Community Health Councils, Inc. (CHC), a health advocacy organization of about 40 people, along with its allies and neighborhood residents, successfully engaged the Los Angeles (CA) Department of City Planning (Department) in a partnership to reshape both the city's Health & Wellness Element (Element) and to integrate food (and other health-related) provisions into three South Los Angeles community plans. Although this is an example of changing approaches to participation since Arnstein's (1969) article, the process also suggests the relevance of her article regarding the continuation of her concerns about planning equity and power sharing, especially in the implementation phase.

This process represents a significant shift from the manipulative and tokenistic planning processes Arnstein (1969) famously portrayed in her ladder of participation. In their advocacy for the Element, CHC and its allies exhibited independent power in fighting for the adoption of the Element and directly affected its provisions. In a complementary action, CHC used more informal, discretionary approaches with key Department personnel to create a separate collaborative participatory process to campaign for specific items they wanted included in the three plans. We focus our analysis on one of these, the West Adams plan. In these processes, the community was not passively listening to or simply reacting to invitations from the city; CHC was aggressively ensuring community input and influence, one of Arnstein's (1969) key recommendations.

CHC's model for social change, graphically described in Figure 1, works to achieve health equity through innovative, multifaceted, and community-led policy approaches (Lewis et al., 2011; Sloane et al., 2006). The social determinants of health are central to the model, which recognizes social, economic, and environmental conditions as primary contributors to disparate health outcomes (Barton & Tsourou, 2013; Corburn, 2007; Marmot & Wilkinson, 2006). The CHC model adapts community-based participatory processes

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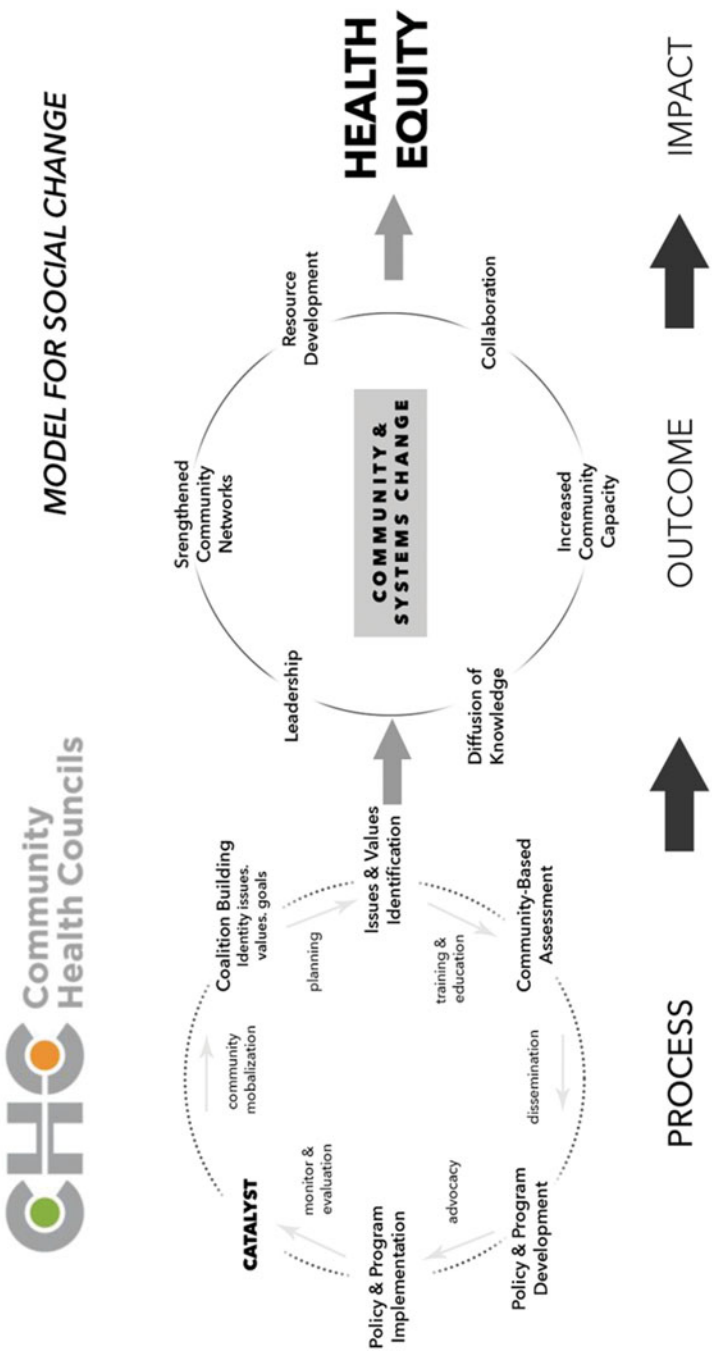

Figure 1. CHC model for social change. Note: Redrawn by Jackie Castillo.
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by centering community expertise and surrounding it with the support of academic contributions from public health, sociology, and urban planning (Lewis et al., 2011). It serves as a "countervailing" force against circumstances where institutional power dominates processes (Fung & Wright, 2003).

In this study we consider how CHC's processes of change directly affected the adoption of the Element and heavily influenced the West Adams community plan update. To understand how their actions shaped the planning process, we compare the West Adams plan with four other community plan updates developed for different subareas within the city of Los Angeles, including two plans (treatment) in which CHC fought for provisions and two plans (control) in which they did not. We also briefly discuss the limitations and challenges to implementation because all of the plans under discussion except one were adopted after the completion of our study.

Plan Structures

The umbrella of the city's land use planning is the General Plan Framework. The California Supreme Court dubbed the general plan the "charter to which [zoning] ordinance[s] must conform, but the general plan extends far beyond zoning and land use" (Governor's Office of Planning and Research, 2017, p. 10). General plans should 1) express the community's development goals and 2) provide guidance on the distribution of both public and private future land uses (Governor's Office of Planning and Research, 2017).

The state of California requires each general plan to include seven elements: land use, circulation, housing, conservation, open space, noise, and safety (including environmental justice). Cities can add optional elements such as water, climate change, equity, or community development if they feel the issue is not covered by the required elements (Governor's Office of Planning and Research, 2017).

The insertion of food and other health concerns into comprehensive plans represents a distinct change from previous practice. In 2012, Richmond was the first California city to add a health element. Richmond is a port city with significant environmental health burdens and poor health outcomes. The decision to develop a health element came as a result of a generation of research and practice demonstrating that land uses influence the health and wellbeing of community residents and the continuing adverse impacts on unrepresented communities (Corburn, Curl, Arredondo, & Malagon, 2015). Advocates and practitioners have argued for the inclusion of health provisions in plans and zoning codes as a means of improving quality of life (Coutts, 2015; Ricklin & Kushner, 2014).

In Los Angeles, the effort to develop an element for the citywide General Plan Framework occurred simultaneously with multiple efforts to update the city's 35 community plan areas, which together comprise the land use element of the general plan. Originally formulated in the 1970s to respond to the city's enormous population and geographic size, the city's community plans "provide the specific neighborhood-level detail, relevant policies, and implementation strategies necessary to achieve the General Plan objectives" (Los Angeles Department of City Planning, 2013a, p. xii). Because multiple planning processes occurred almost simultaneously within the same city and were facilitated by the same planning department, we have a unique opportunity to analyze and compare plan processes and outcomes to measure CHC's success in addressing health equity through multiple innovative, multifaceted, and community-led policy approaches.

Activating Los Angeles Planning

Los Angeles is a global city of roughly 470 square miles with a population of 3.9 million people, second in the nation only to New York City (U.S. Census Bureau, 2017). Los Angeles is the first global city to have a previously minority population, Latinos, emerge as the majority population. The city is a diverse immigration hub, home to significant populations of Koreans, Chinese, Japanese, Central Americans, and others (U.S. Census Bureau, 2017).

Although urban development in the city expands to accommodate its growing population, some communities remain on the margins of this increased growth and development. South Los Angeles (South LA), a historically African-American community, has a poverty rate ranging from 21.5% to 33% in the three community plan areas and a disproportionate health burden, with the highest rates of nutrition-related chronic diseases in the region (Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology, 2017). These health disparities partially derive from adverse social determinants of health, a combination of social, economic, and environmental conditions that influence one's health behaviors and health outcomes (Shaw, 2008). Field studies of the South LA resource environment reveal the area has limited access to resources that support healthy behaviors such as grocery stores, parks, and health care facilities (Lewis et al., 2011; Sloane et al., 2003, 2006).

Community Health Councils is a small nonprofit formed after the 1992 civil unrest as a South LA–based health policy organization addressing health care issues

in vulnerable communities. CHC was born out of a recommendation from the Task Force on Health Care Access to the Los Angeles County Board of Supervisors after a series of public forums. At its origins, CHC convened 12 health coalitions across the South LA region composed of community- and faith-based organizations and health care providers to understand and reduce gaps in health disparities and access to health care. Over the next decade, learning from its coalition dialogues, the organization expanded its activities to address broader social determinants of health, including resource environment disparities (Sloane, 2012).

The organization took multiple approaches to affecting the health of the community, including collaborating in the development of a fresh food fund at the state level, organizing for the calorie counts on restaurant menus, and other public policy changes. In 2007, CHC succeeded in getting the Los Angeles City Council to pass a "fast food ban," which temporarily prohibited new standalone fast food restaurants in three South LA community plan areas. To date, CHC is a coalition-driven organization, facilitating coalitions on a variety of public health issues; however, the formal councils are no longer convened.

CHC recognized that health inequity could only be addressed through comprehensive solutions that extended beyond health care into broader policy, systems, and environmental changes (Feldstein, 2007). In the aftermath of the temporary ban, CHC collaborated with city planners to amend the General Plan Framework to institutionalize it (Lewis et al., 2011). The result was a new relationship between CHC and planning and public health officials. Planning department staff later noted that

> CHC put together this group, including the Department of Public Health, because the second phase in terms of all this was not just the regulatory sort of stick, but there was to be this healthy restaurant incentive program that was to move forward as well, and I see it's a program in the adopted Health [& Wellness] Element, and also in the [West Adams] Community Plan. (City Planner 1 Interview, 2014)

In 2006, the Planning Department committed to updating several of its 35 community plans, including South LA's three community plans. Following its initial planning advocacy experiences and leveraging its model for social change, CHC began organizing residents to participate in the meetings and to craft provisions for the South LA plans (Sloane, 2006). Few groups were fully cognizant of the complex factors influencing healthy food access in historically underserved communities (Lewis et al., 2011). As Figure 2 demonstrates, solving health disparities through planning required improved planning literacy among community stakeholders and better understanding of food systems and health equity by planners. Advocates ultimately equipped city planners with community health equity data that framed plan priorities and an expanded toolbox to create more innovative land use policies tailored to the specific health needs of communities (Los Angeles Department of City Planning, 2015).

These changes were neither one-sided nor easy, and the process has taken well over a decade to establish. After the Great Recession of 2008 forced the city to make significant staff reductions, all efforts to update community plans were put on hold. Not long after the processes relaunched, a successful lawsuit against the Hollywood Community Plan froze progress again in 2012. During this hiatus, CHC worked with community allies, academic experts, and Department officials to develop an atlas of community health indicators that became the basis of data on which the Element for the general plan was developed, partially through funding CHC obtained from the Centers for Disease Control and Prevention. CHC used that hiatus to continue building relationships with Planning Department staff by meeting with Department employees assigned to the West Adams, South Los Angeles, and Southeast Los Angeles community plans to share pertinent community health information and to advocate for provisions that CHC and its allies wanted included, especially fast food regulations.

Evaluating the Planning Process

Stevens (2013) provides nine categories to consider in evaluating community plans, including fact base, goals, policies, public participation, implementation, monitoring, and interorganizational coordination. Berke and Godschalk (2009) conducted a meta-analysis of studies of plan quality that yielded categories similar to those of Stevens (2013) but emphasized the difference between internal characteristics of the plans themselves and external characteristics such as compliance, interorganizational coordination with other plans and policies, and the understandability of plans for a wide range of readers through plan organization and presentation. Berke and Conroy (2000) analyze comprehensive plans for sustainable development through a literature review that yielded six principles for sustainable development, which provided a framework for content analysis in 30 comprehensive plans. Researchers working with the APA adopted a similar framework development method to analyze how public health is addressed in 18

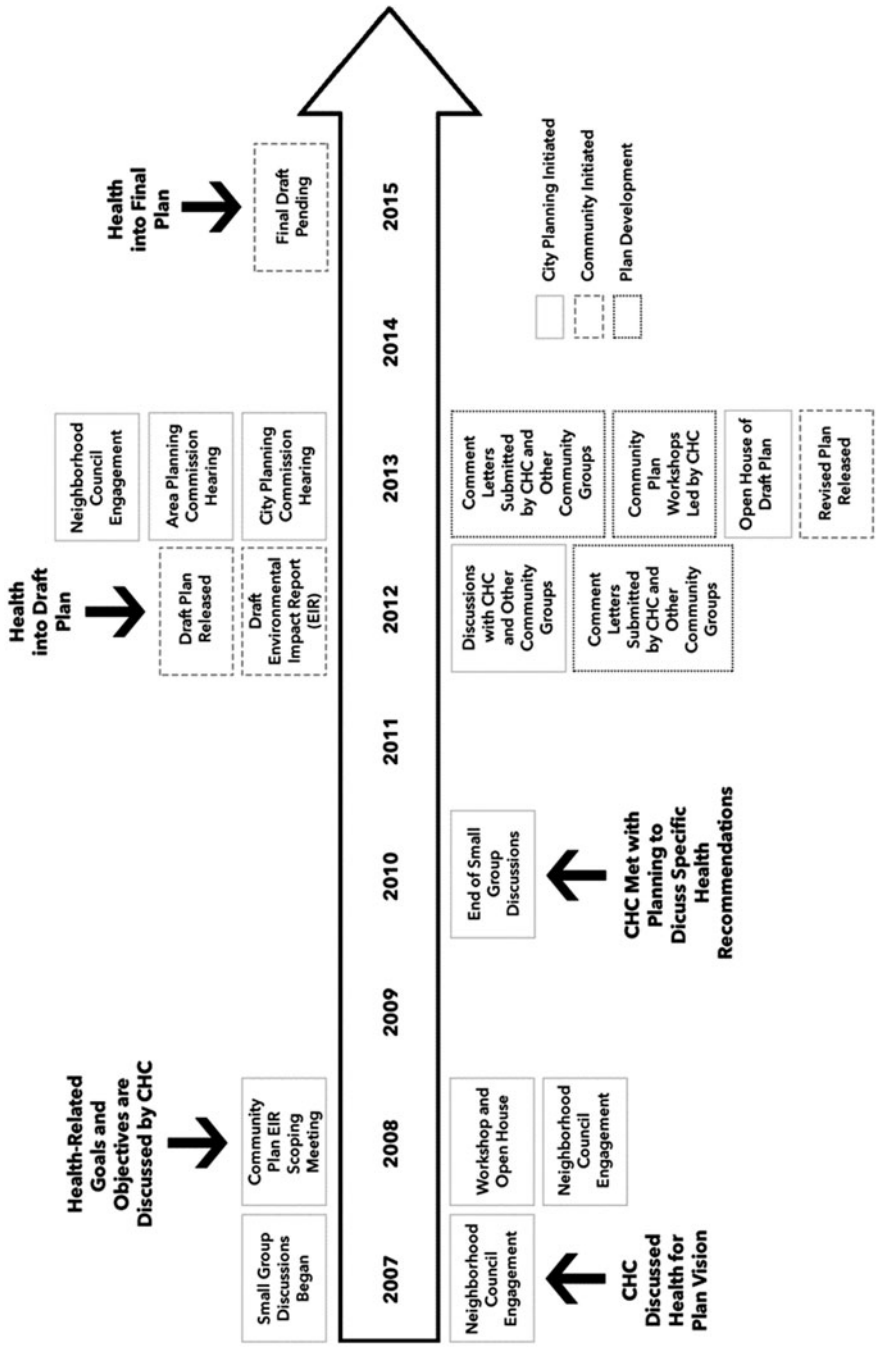

Figure 2. West Adams Community Plan engagement timeline.
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comprehensive plans and four sustainability plans across the United States (APA, 2012).

Although each of these studies influenced our methodology, in this study we examine whether the process of community engagement affected plan provisions (Balsas, 2012; Seasons, 2003), especially whether the process was "authentic." Recent studies have focused on establishing best practices for "authentic participation," including cultivation of leadership in underserved communities that diversifies stakeholder engagement throughout all phases of the process (Berke & Godschalk, 2009; Godschalk & Rouse, 2015). APA's *Best Practices for Comprehensive Plans* defines authentic participation as "ensur[ing] that the planning process actively involves all segments of the community in analyzing issues, generating visions, developing plans, and monitoring outcomes" (Godschalk & Rouse, 2015, p. 3).

These best practices often situate planning practitioners as the primary facilitators of participatory planning processes (Healey, 1998; Innes & Booher, 1999). Dominant participatory planning paradigms, such as collaborative planning, incorporate a "civics-based model of planning that delegates responsibility for preparing plans directly to affected stakeholders" (Gunton & Day, 2003, p. 5). Although effective implementation of these planning approaches involves diverse stakeholder input, planning practitioners are primarily the stakeholders empowered to initiate or "delegate responsibility" within legitimized participatory processes.

We argue for an expanded conception of authentic participation that includes the role of community institutions in initiating legitimate collaborative planning processes, with or without delegated responsibility from planning departments. We profile CHC's model for social change as a holistic example of authentic participation and analyze where common collaborative planning benchmarks may succeed or fall short in fully encapsulating the goals and intentions of the participatory processes. In doing so, we show how planners and community members can not only craft a process that rises up Arnstein's ladder (Arnstein, 1969), but also ensure a more equitable process that engages critical community issues, such as food access.

Methods

Sites

Between October 2013 and April 2015, our team reviewed relevant planning documents and processes for developing the Element of the general plan and for updating five of the 35 community plans that together comprise the land use element of the general plan. We completed our analysis in April 2015. Table 1 shows the list of plans we reviewed and their status in 2018. Although we focus our attention on the adoption of the Element and the update of the West Adams Community Plan, in some analyses we also include two other community plans, South Los Angeles and Southeast, that CHC and its allies directly attempted to influence, and two control plans, Hollywood and San Pedro, in which the coalition was not active.

The South Los Angeles community is a historically African-American community with the poorest overall health indicators anywhere in the city, as evidenced by the Community Health and Equity Index, which weights 115 indicators, including demographic, socioeconomic, land use, transportation, food environment, and pollution burden (Los Angeles Department of City Planning, 2013a). San Pedro is adjacent to the Port of Los Angeles and suffers from environmental pollution burden as well as low incomes; nevertheless, the life expectancy at birth in San Pedro is more than 5 years higher than that in parts of South LA (78.2 years compared with 72.8 years in Watts within Southeast LA). The Hollywood community plan area has an 80.6-year life expectancy rate at birth and is wealthier and Whiter than the other four community plan areas analyzed, but is representative of the diverse city of Los Angeles (City of Los Angeles, 2013).

We thus chose Hollywood and San Pedro as our control community plan areas because they represent very different communities and update processes. The Hollywood Community Plan has been the subject of intense conflict, leading to judicial action. San Pedro is a harbor-adjacent area with economic demographics similar to those of South LA and underwent an update process at the same time the South LA plans were being updated.

Research Design

As detailed in Table 2, we evaluated the participatory process through the analysis of current community plans; drafts and updates of new community plans; and all documentation related to the updates, city clerk files, and all comment letters submitted by the public as part of the community participation process.

We conducted stakeholder interviews with community members, city staff, CHC staff, and coalition members. We evaluated the ability of CHC and its allies to influence plan provisions through a natural experiment design and comparative analysis of relevant planning documents and processes.

We evaluated the reliability of the coded data through intercoder reliability between two assigned student coders and a senior researcher who oversaw and reviewed all coded content.

Table 1

City of Los Angeles plans reviewed by the research team.

Plan	Date previous plan adopted	Date update began	2015 Status	2019 Status
Health & Wellness Element	None	2012	Adopted 2015	Adopted 2015
West Adams CP	1998	2006	Draft	Adopted 2016
South LA CP	2000	2007	Draft	Adopted 2017
Southeast LA CP	2000	2007	Draft	Adopted 2017
Hollywood CP	1988	2006	Drafted 2010; adopted 2012; rescinded 2014	Redrafted 2017
San Pedro CP	1999	2006	Draft	Adopted 2018

Note: CP = Community Plan.

Table 2

Data sources for evaluating the planning documents.

Data source	Type	Description
Public documents	Publicly available documents	Current, drafts, and updates of community plans, general plan elements, and community plan implementation overlays; design guidelines, land use maps, proposed implementation programs
	Documentation of public comments	City clerk files, archives from city planning webpages, CHC comment letters, issues and opportunities summaries from city planning

Measures and Data Analysis

As detailed in Table 3, we assessed activities and public materials related to the engagement processes, including those created by the Department and the complementary one driven by CHC's model for social change. We conducted stakeholder interviews with two CHC staff, four city planners, and four CHC coalition and committee members, providing key insights into the process. We assigned a single student researcher to observe myriad public and community meetings related to their designated plan to ensure that consistent, verifiable information was obtained. At times, the assigned student was not available, in which case another student substituted.

We conducted a qualitative assessment through text mining, word association, and content analysis using NVivo 10 software to track the planning process and analyze levels of community engagement and to identify the extent to which CHC's feedback and priorities were incorporated into the plans.

Last, to describe changes in the frequency of health and food terminology, we applied a simple difference-in-difference approach. Difference-in-difference assesses the impacts of a specific intervention or treatment by

Table 3

Data sources for evaluating the planning process.

Data source	Type	Description
Meeting notes	Public meetings	DCP, community plan advisory committees, city planning commission, city council, neighborhood councils
	Partner and coalition meetings facilitated by CHC	United for Health, Partners in Health, The South LA Food Policy Roundtable Coalition, Coalition for an Active South LA
Stakeholder interviews	Interviews	CHC staff, community members, coalition members, grant partners, DCP, CHC advisory board members
Electronic communication platforms	Relevant websites and pages	DCP, community plan update websites, CHC, Health & Wellness Element
	Email notifications	DCP, CHC, community organizations, neighborhood councils
	Social media	Facebook pages for each plan process

Note: DCP = Department of City Planning.

comparing changes between a treatment and control group over two or more observable time periods in a natural experiment (Angrist & Pischke, 2008). We substantially simplified the typical method to figuratively demonstrate the "effect" of authentic participation on plan provisions. The modified difference-in-difference model we used is as follows:

$$Impact_1 = (South\ LA_{POST} - South\ LA_{PRE}) - (Control_{POST} - Control_{PRE}) + E$$

The previously existing plans were our "pre" group; the draft updates were our "post" group. Plans driven by authentic participation were considered the "treatment" group (West Adams, South LA, and Southeast LA), whereas plans in which CHC and its allies were not involved were considered the "control" group (San Pedro and Hollywood).

Results

Our analysis reveals that CHC directly influenced the process and the provisions of the Health & Wellness Element, the West Adams Plan, and the other treatment plans. The alliance amplified the community's voice. CHC directly influenced provisions in the treatment plans and inserted a more holistic and sophisticated conception of health with more specific, actionable, and measurable health equity policies and provisions incorporated compared with those of the control plans.

Framing Health in the General Plan

CHC and its community allies began advocating for a comprehensive Health & Wellness Element after seeing the successes in Richmond and the advocacy for healthy plan provisions offered by Public Health Law & Policy (now ChangeLab Solutions; Public Health Law & Policy & Raimi Associates, 2008). CHC actively worked with allies such as the California Endowment, various food and physical activity interventionists, and academic experts (disclosure: CHC representatives and one coauthor were on advisory boards) to educate policymakers regarding the benefits of the new Element. By 2014, the Department requested public input. Foundation funding allowed the city to hire a staff member solely to coordinate community engagement for the Element, ensuring that the mosaic of health-related concerns of a

diverse constituency across the city was integrated into the plan. As part of this process, CHC wrote a detailed comment letter regarding potential provisions related to a range of health issues. Due in part to the extensive engagement process, there was no opposition to the inclusion of the Element of the General Plan Framework once it was presented to the city council for approval in April 2015.

As Table 4 shows, we found that in CHC's key interest area, their concept for an innovative "healthy kids zone" surrounding schools in historically underserved communities, the Element largely adopted their language (59% of language matched the language in the comment letter). Their call for a healthy restaurant program was almost identical to the language in the Element (91%). Although the language calling for an urban garden district (33%) and urban agriculture liaison (21%) diverged more, CHC still had a major influence in the inclusion of these provisions and how they were conceptualized.

Influencing the West Adams Plan

Even as CHC was working with allies to amplify food in the General Plan Framework, they continued their efforts to ensure specific health provisions were included in the West Adams Plan. As detailed earlier in Figure 2, the Department developed an extensive participatory process throughout each phase of plan development. Inequitable healthy food access in the West Adams community was first discussed early on in the process, in the "issues identification" phase. A city planner noted, "Fast food limitations, then grocery stores, then increasing access to healthy food options. That really was probably the prime issue that came up through our outreach, and CHC certainly was front and center with those working groups" (City Planner 1, 2014). This focus on healthy food access, the planner stated, "guided the thrust of the plan," leading to a broader integration of health equity into the plan's vision for improving quality of life.

Table 4

CHC comment letter language compared with health element provisions.

Policy recommendation	Percentage duplicated
Urban agriculture liaison	21
Urban garden district	33
Healthy Restaurant Program	91
Healthy Kids Zones	59

The efforts started at the very beginning of the process. In Los Angeles, the county, not the city, oversees health care and public health, so many concerns that community members had related to planning and the built environment did not fall under the purview of Department. Because of this governance structure, health had not previously been a focus or area of expertise within the City Planning Department. An analysis of public comments in the visioning process of the West Adams Community Plan revealed that the community raised health as a primary concern of community residents. As a result, the Department worked with the Los Angeles County Department of Public Health to develop and refine policies, provisions, and programs to more effectively address communities' desires and concerns regarding health. Thus, CHC helped to establish not just a stronger engagement process but also interdepartmental learning.

Through power analyses and advocacy training workshops, CHC also helped residents recognize the influence of their participation on the future trajectory of development in their communities. They highlighted that their power to change communities' built environments could be maximized through engagement in the planning process. CHC also helped leverage the power of community residents to educate elected officials. Community residents visited with their elected representatives to ensure that healthy communities was a priority for them, even if health was not initially a primary concern for the elected official. The community's influence played an integral role in cultivating the political will for the health-related provisions in the plan.

The draft West Adams Plan was released in September 2012. The plan included provisions for healthy food production, development, and distribution as well as the transfer of the fast food density restrictions from the general plan amendment into all three South LA community plans. However, the draft exempted numerous neighborhoods from the proposed restrictions at the recommendation of elected officials and restaurant industry groups. Only 2 years earlier, the Department had asserted that the oversaturation of standalone fast food restaurants in South LA was "detrimental to the quality of life of the residents, which, if unabated, may lead to eroding public welfare and good planning" (Los Angeles Department of City Planning, 2010). The Department's political neutrality limited its ability to adequately advocate for the concerns and desires expressed at the beginning of the plan development process.

CHC engaged in an inside–outside community organizing strategy in response to the Department's position. CHC both exerted leadership in the Department's participatory process and, starting in 2013, created a tandem participatory process that specifically focused on promoting health equity and healthy food access. Following its model for social change, CHC began organizing a cross-sector coalition of community residents, businesses, and organizational partners focused on advancing health through land use and planning. In partnership with the coalition, CHC conducted a series of community-based participatory research studies on the saturation of fast food restaurants in South LA in comparison with more affluent areas in Los Angeles (Lewis et al., 2005; Sloane et al., 2006). CHC also facilitated several planning workshops to educate local residents on how to participate in planning processes and opportunities to promote healthy development and food access through planning. Throughout the partner development, issue identification, and assessment processes of the model for social change, CHC engaged local community clinics, hospitals, health policy organizations, school programs, and local community colleges and universities, most of which had never participated in a planning process.

Informed by findings from the community-based participatory research studies and contributions from coalition partners and engaged community residents, CHC submitted a series of in-depth recommendations advocating for the preservation of fast food regulations and healthy development incentives through the planning department's participatory process. The Department's participatory process spanned from 2006 to 2015 and included open houses, Department-initiated community workshops, written public comment periods, and public hearings.

When the fast food restaurant industry began actively opposing regulations recommended by the community, CHC embarked on a petition campaign, neighborhood calling, and neighborhood canvassing, which ultimately led to more than 200 South LA stakeholders participating in the April 2013 Planning Commission hearing on the plan. At this hearing, dozens of residents provided public comments or submitted letters, and the community presented petitions with more than 1,000 names that urged the commission to prioritize health in South LA and eliminate the proposed exemptions on the fast food regulations. As a result of these efforts, the Planning Commission recommended the plan be adopted contingent upon the integration of CHC's recommendations to eliminate the fast food exemptions and prioritize community health. By June 2016, the Hollywood legal challenges had lifted, and the Los Angeles City Council adopted the revised West Adams Plan with the fast food recommendations. The South and Southeast LA plans were adopted the following year with no fast food exemptions included.

Plan Provisions

We started our analysis of CHC's influence by examining all 35 existing (1998–2004) community plans, as reported in the last column of Table 5. Our analysis shows that although broad terms such as *health*, *transit-oriented development*, and *mixed use* appeared regularly, and traditional planning concerns such as *oil drilling and air quality sporadically* appeared, newer health-related concerns such as active transportation, physical activity, and obesity were entirely absent. Food was mentioned in five plans fewer than five times each, largely related to economic development.

In our treatment and control plans, "food" is not mentioned, except once, in any of the *previous* existing plans. Examining the change to the updates in Table 5, the difference-in-difference calculation finds that the change in food frequency was 14.33 more in the updated treatment plans than in the updated control plans. The greatest shifts were in the West Adams (+24 mentions) and South LA (+16 mentions) plans.

Further, food was not just a descriptor of the retail environment. Food access was integrated into plan objectives, policies, and implementation strategies as a resource for supporting community health and well-being. Table 5 shows that every indicator related to healthy food access increased in the South LA updates. In the San Pedro control plan, updated in 2014 after the South LA plan updates, food was also mentioned as integral to quality of life. However, in stark contrast to the aforementioned policies and strategies included in the South LA plans, no policy provisions or implementation strategies were included in the control plan updates to increase healthy food access.

The change in the frequency of health terminology in the South LA plans was significantly greater than the change in frequency of the control plans updated around the same time, with a difference-in-difference output of 33.76 for the South LA plans. Yet, the way in which health is discussed changed in all the plans updated after the West Adams Plan. They moved from a traditional "health and safety" planning conception to one that considers physical activity, obesity, food, and health care access. Indeed, health concerns appear more frequently in *all* new plans.

Evidence of this broader conception of health is visible in the following passage from the West Adams Plan: "A growing body of research has shown that there

Table 5.

Change in frequency of health and health-related terms from existing to updated plans, with measure of difference-in-difference.

	South LA community plans			Comparison community plans		Difference-in-difference	Older plans (1988–2005) average
	West Adams 1998–2013	South LA 2000–2014	Southeast LA 2000–2014	Hollywood 1988–2010	San Pedro 1999–2014		35 existing plans
Health	+58	+47	+44	+15	+16	+33.67	6.6
Health and safety	+2	−1	−1	0	−4	−2	2.9
Public health	+3	+10	+10	+5	+5	+2.67	0.26
Food	+24	+16	+12	+3	+3	+14.33	0.46
Physical activity	+4	+2	+2	0	+2	+1.67	0
Obesity	+2	+3	+3	0	+2	+1.67	0
Active transportation	+1	+1	+2	0	+1	+0.83	0
Equity	0	+1	0	+1	+1	−0.17	0.23
Oil	+17	+29	+22	0	0	+22.67	1.29
Air quality	+4	+5	+3	+6	+3	−0.5	1.31
Mixed use	+50	+10	+18	+45	+3	+2	15.83
Transit-oriented development	+38	+27	+23	+3	+10	+25.83	1.12

Note: Plus and minus represent changes in frequency of the health-related terms from existing to new plans. Average of all existing plans is shown in the last column. Difference-in-difference was calculated by averaging three South LA plans and two comparison plans and then dividing the difference between the averages.

are connections between development patterns, community design and health outcomes. Crafting a more health-friendly Community Plan is critical to the overall health of a community." They go on to include "equitable access to recreation facilities," "grocery stores and healthy foods," and "safe, active transportation options such as biking and walking," as well as "health services," "affordable housing," and "safe public spaces" (Los Angeles Department of City Planning, 2013b, p. 3–7).

Using the APA measures of comprehensive plans addressing public health (APA, 2012; Ricklin & Kushner, 2014), Table 6 reflects the holistic integration of healthy eating and active living in the treatment plans' guiding principles, collaborative processes, plan provisions, policies, and objectives. Thus, through authentic participation, CHC not only influenced the process, it independently initiated a participatory pathway that succeeded in getting specific, actionable policies and new standards to address community health issues identified through the process. CHC also helped build the Planning Department's capacity for understanding and recognizing the role planning plays in influencing food systems planning and community health more broadly (Raja, Picard, Delgado, & Baek, 2014).

Plan Implementation

Since our research period ended in 2015, health advocates and residents have focused on implementation, wary of the growing specter of displacement and gentrification in their neighborhoods. Arnstein (1969) recognized the importance and limitations surrounding implementation: "Little or no thought has been given to the means of insuring continued citizen participation during the stage of implementation" (p. 221). Several healthy food access policies have been adopted in line with these plans, including new legislation to encourage urban agriculture incentive zones, expansion of the healthy neighborhood market conversion program, and a new policy requiring electronic benefits transfer (EBT) access at all farmers' markets on city property.

Similarly, as suggested by Table 7, the City's Sustainable City Plan provides a roadmap to make the healthy food access policies embedded in the Health & Wellness Element more actionable. Still, advocates in South LA put forth The People's Plan to ensure existing residents were at the forefront of any planning or policy decisions both to improve health and to prevent displacement (United Neighbors in Defense Against Displacement, 2016). The coalitions working with South LA residents on The People's Plan have modified CHC's community planning curriculum to further engage residents in the planning and advocacy process.

Even with these positives, the pace of implementation has been both slow and irregular. The Department took almost 2 years to publish the first set of implementation steps, and steps toward implementation of concepts such as the Healthy Kids Zone are still not fleshed out. As displacement fears have escalated, residents worry that amenities such as new parks are signals of gentrification, so local resistance is also rising. The concern that the Department will move ahead in implementation with little or no thought about a continuing partnership remains a worry.

Discussion

In the end, the efforts by CHC and its allies do not fit neatly into Arnstein's rungs (Arnstein, 1969). As Arnstein (1969) admitted, in "the real world of people and programs, there might be 150 rungs with less sharp and 'pure' distinctions between them" (p. 217). This example exemplifies that admission. We did confirm that a planning partnership with both a city-led planning process and a parallel community-led process can succeed in expanding the inclusion of community health-related issues and solutions. This finding represents the recent recognition of health-related issues, especially food systems issues, as planning concerns and the impact of CHC and its allies' abilities to affect the outcomes of the community plan process. Yet we also found that even with their concerted, effective participation, the key remains ensuring a carefully drawn implementation process and plan with ongoing community input and oversight, or the whole process may end up being more like placation than a true partnership.

An important element of the participatory process was the elevation of food systems within the planning process. Since Pothukuchi and Kaufman's (2000) pioneering article, food has become an important planning issue of discussion, not only for economic development but as community development due to the social capital benefits from alternative food resources such as farmers' markets and community gardens. Still, moving food system issues from the field into plans has been a slow process. The Health & Wellness Element and West Adams Plan represent a model for infusing the consideration of healthy food access into the formal planning process.

In this study we show that CHC and its allies initiated a process that played a critical role in the integration of food systems issues into the Element and the community plans. As the Department stated, "Within the South Los Angeles Planning Subregion, CHC has been instrumental in developing and implementing both short term and long range policy, program and

Table 6

APA indicators compared by existing plans and plan updates.

Indicator	West Adams 1998 plan	West Adams 2013 draft	South LA 2000 plan	South LA 2014 draft	SELA 2000 plan	SELA 2014 draft	Health & Wellness Element 2015
Guiding principles include community values, public health, social equity?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of collaboration with community health stakeholders?	No	Yes	No	Yes	No	Yes	Yes
Plan supports local food production?	No	Yes	No	Yes	No	Yes	Yes
Plan identifies healthy eating and healthy food options as important to a high quality of life?	No	Yes	No	Yes	No	Yes	Yes
Objective to increase number of grocery stores?	No	Yes	No	Yes	No	Yes	Yes
Policy bans or limits convenience stores, fast food outlets, or liquor stores in neighborhoods?	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Note: SELA = Southeast LA.

Table 7

Implementation of health element (2015) and sustainable city plan comparison (2015).

Health element action description	Plan's sustainability objectives
Increase to at least one community garden (1 acre) per 2,500 households per CPA	Increase urban agriculture sites in LA from 2013 baseline by at least 25% (by 2025) and 50% (by 2035)
Increase access and availability of healthy food retail options in low-income and underserved areas, with emphasis on fresh fruits and vegetables	Ensure that all low-income Angelenos live within 0.5 mile of fresh food by 2035
Increase number of grocery stores to at least 0.6 for every 10,000 residents (current citywide average) per CPA	
Increase number of residents living within 1 mile of farmers' markets	
Increase number of farmers' markets participating in Market Match	
Increase number of healthy food retailers accepting CalFresh EBT by 50% in low-income CPAs with highest percentage of households participating in SNAP	N/A
Increase CalFresh EBT enrollment of eligible recipients	

Note: CPA = community plan area; EBT = electronic benefit transfer; SNAP = Supplemental Nutrition Assistance Program.

land use regulation regarding access to the local, state and national level" (Los Angeles Department of City Planning, 2013b, p. 1–16). By being willing to develop and lead a complementary participatory process and convincing the Department to collaborate with that process, CHC has demonstrated important improvements in participatory planning since Arnstein's (1969) critique.

However, the need for the community to push hard for inclusion of diverse community voices suggests that Arnstein's initial reason for writing her landmark article is very present even if her ladder may seem archaic. Health (including food) provisions will only be meaningfully or actionably integrated into plans through the insistence of public voices. Even though food, environmental justice, complete streets, and other elements of a healthy city are acknowledged in the everyday language of planning, the successful integration of actionable provisions in community plans is still a struggle, 50 years after Arnstein (1969) called out the planning profession by reminding them that everyone "vigorously applauded" participation but reduced their support to "polite handclaps" when the conversation moved to redistribution or real sharing of power (p. 216).

Critics of CHC and its allies would point out that their involvement conflicted with other community interests, especially those of homeowners, who emphasized divergent provisions. Others critique the process because it emphasized a limited number of "health" issues, not including housing, which has become the city's single most important social planning issue and is now recognized by the county Health Department as the most significant social determinant of health (County of Los Angeles Public Health, 2015).

Still, the results of our investigation show conclusively that the activities of CHC and its allies resulted in heightened and more authentic community participation with a realized sense of partnership resulting in more holistic consideration of health issues and more specific, actionable policies.

Conclusion and Takeaways for Practice

CHC's framing of food access issues at the intersection between health and planning contributed to a paradigm shift in the Department. According to theorists Dogan and Pahr (1990), hybridization between

disciplines and fields of practice fills gaps left by the rigidity of narrowly focused disciplines. Here, the CHC model for social change provides a framework to create a collaborative and authentic participation process. This participation included the development of a community-led participatory planning process that complemented the Department's existing process.

Thus, we suggest that practitioners should strongly consider partnering with—not only including—strong, active, community-based groups in their jurisdictions to produce a more equitable, inclusive planning process. Practitioners should also recognize community-initiated planning efforts as legitimate contributions to the participatory planning process that should have equal weight in the inclusion of planning provisions. As Arnstein (1969) documented regarding model cities 50 years ago, creating participatory plans that do not fully share power with communities diminishes the planning process by reducing participation to mere manipulation. Her insight, although sometimes criticized as out of date, seems remarkably apropos according to the process we describe here. Critically, the Department recognized CHC and its allies as equal partners in the participatory planning process, producing a product with greater potential to improve the quality of life of South LA residents than did previous South LA plans. We doubt that the provisions reported here would have occurred without this partnership, suggesting the importance of teaching and implementing planning practice as an institutional and community collaboration.

Thus, the inside–outside community organizing and engagement strategy CHC used infused equity into the planning process by lifting up communities with the highest rates of poor health outcomes and prioritizing health-related provisions in those community plans, rather than a blanket approach for all community plans. The contributions by CHC and its partners allowed planners to better align needs with plan provisions in updated South LA plans. The long process, although frustrating for all participants, may well have created time for relationships to mature, for community partners to more effectively organize, and for all participants to better understand and define the proposed health provisions.

Finally, the CHC model provided an improved platform for potential implementation. In reviewing 40 official community plans in British Columbia (Canada), Stevens (2013) finds that plans tend to be strong in laying out future visions and specifying goals and policies to reach that vision, yet are weak in implementation, monitoring, and evaluation. Compared with the old South LA community plans, as well as the control plans for Hollywood and San Pedro, the treatment community plans provide specific implementation programs and more powerful enforcement mechanisms through new development standards, even if progress has been slow. Our findings suggest that focusing on implementation is an essential element of successful community planning.

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